MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BLOOD LEAD ANALYSIS REPORT
DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE # R325.9082 AND R 325.9083

PATIENT INFORMATION

To be completed by Parent/Guardian or Patient
PLEASE PRINT

Last Name _____ First Name _____ M. Initial _____

Address – No PO Boxes, please _____ Apt. # _____ City _____ State MI Zip _____

( ) _____ Birthdate (month/day/year) _____ Parent/Guardian Name (please print) _____
Area Code and Phone Number

Race (Check all that apply):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Middle Eastern or Arabic

Sex:
- ☐ Male
- ☐ Female

Funding Sources:
- ☐ Self Pay/Insurance
- ☐ Medicaid

ID# (Medicaid only): _____

If Patient is an adult (≥ 16 years):

Employer: _____

Social Security #: _____

PROVIDER/PHYSICIAN INFORMATION

To be completed by provider's office

Clinic, Hospital or Agency Name _____ Physician name _____

Mailing Address _____ City _____ State _____ Zip _____

( ) _____ Fax Number _____
Area Code and Phone Number

SPECIMEN COLLECTION INFORMATION

To be completed by person who draws specimen

Specimen Collection Date _____

Source of Specimen ☐ Capillary ☐ Venous ☐ Filter Paper

LABORATORY INFORMATION

To be completed by testing laboratory

Laboratory Name _____ Specimen ID Number _____

( ) _____ Analysis Date _____
Area Code and Phone Number

BLOOD LEAD LEVEL in Micrograms per Deciliter _____ (round to nearest whole number, please)